DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445278	A. BUILDING _____ B. WING _____	10/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKEWOOD NURSING CENTER, INC	332 RIVER ROAD DECATUR, TN 37322

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During annual recertification survey and complaint survey #30695, #31423, & #32011 conducted on October 14-16, 2013, at Brookewood Nursing Center, no deficiencies were cited in relation to complaints under 42 CFR PART 483, Requirements for Long Term Care.	F 000	This plan of correction is our credible allegation of compliance. "Preparation and or execution of correction do not constitute admission or agreement by the provider of the truth of the facts alleged or deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law."	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to develop an interim care plan for a psychoactive medication for one (#78) of thirty-five sampled residents. The findings included: Resident #78 was admitted to the facility on October 10, 2013, with diagnoses including Syncopal Episodes, Diabetes, Seizures, History of Alcohol Abuse, Dementia, Anxiety, and Depression. Medical record review revealed a physician's order dated October 10, 2013, for Seroquel (antipsychotic) 12.5 mg.(miligram) twice daily. Medical record review of the Interim Care Plan dated October 10, 2013, revealed psychoactive medication not addressed on the care plan. Interview with the Minimum Data Set/Care Plan	F 281	**F281** **SERVICES PROVIDED MEET PROFESSIONAL STANDARDS:** It is the policy of this facility to provide services that meet professional standards of practice. Resident #78 was admitted to the facility on October 10, 2013 and had his interim Plan of Care completed during the admission process. The interim plan of care states that medications are to be administered as ordered by the physician. Seroquel 12.5mg twice daily was ordered on admission, and listed on the history and physical as a medication taken at home prior to hospitalization. The interim care plan was updated to specify Seroquel use. All newly admitted residents were potentially affected by the cited deficiency, on October 25, 2012, the Director of Nursing reviewed the interim care plans of all residents admitted to the facility who did not have a comprehensive	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	Continued From page 1 Coordinator (MDS) in the MDS office on October 15, 2013, at 2:00 p.m., confirmed the care plan did not address the psychoactive medication.	F 281	assessment and interdisciplinary care plan completed. No other residents were affected.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility policy, and interview, the facility failed to ensure routine hydration for one resident (#32) of thirty-five residents reviewed. The findings included: Resident #32 was admitted to the facility on June 6, 2007, with diagnoses including Dementia, Hypertension, Psychosis, Anxiety, and Congestive Heart Failure. Observation of resident #32 on October 16, 2013, at 1:00 p.m., in the resident's room, revealed the resident lying flat in the bed with the bed in the low position. Further observation revealed the water pitcher on the raised bedside table was pushed against the wall and not within reach of the resident. Review of the resident's care plan revised on August 1, 2013, revealed "...at risk for dehydration and weight loss due to diuretic therapy...with goals including...encourage	F 282	To ensure compliance with providing services that meet professional standards of quality, the Director of Nursing will provide in-service training to the licensed nursing staff regarding inclusion of psychoactive medications on the interim plan of care. The in-service will be done on November 08, 2013. Beginning October 25, 2013, the Director of Nursing will review interim care plans for all newly admitted residents to ensure compliance with the inclusion of psychoactive medications for three months, and report finding to the Quality Assurance Committee (Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Social Service Director, Medical Records, Housekeeping and Laundry Supervisor, Therapy Manager, MDS Coordinator Activities Director and Pharmacy Consultant) monthly for further review or corrective action if indicated. Date of completion November 11, 2013. **F282** **SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** It is the policy of this facility to provide services by qualified staff in accordance with each resident's written plan of care.	

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F 282	Continued From page 2 frequent liquids keeping fresh water in reach of resident..." Review of the facility policy and procedure Hydration, effective September 2012, revealed "...ensure that each resident has fresh water within reach...and follow each resident's plan of care for providing fluids..." Interview of Certified Nursing Assistant (CNA) #4, on October 16, 2013, at 1:05 p.m., in the resident's room, confirmed the water pitcher was not within reach of the resident. Further interview with the CNA revealed "...I did that or (he/she) would try to drink and spill water all over (his/her) face..." Interview with Licensed Practical Nurse (LPN) #4, on October 16, 2013, at 1:15 p.m., in the resident's room, confirmed the water pitcher was out of reach for the resident.	F 282	Director of Nursing had an educational training session with certified nursing assistant #4 on hydration with emphasis on placement of water pitchers within resident reach on October 28, 2013. All residents could potentially be affected by the cited deficiency; the Director of Nursing initiated a room audit on October 21, 2013 for proper placement of water pitchers. An In-service training was held on October 23, 2013 by the Administrator for full staff and in-services notebook for employees who were unable to attend the in-service meeting. To ensure compliance with the hydration policy, the Assistant Director of Nursing will randomly check weekly for 3 months for water pitcher placement, and assign charge nurses to randomly audit on night shift and weekend shifts, for adherence to the hydration policy. Any deficiencies will be corrected immediately. The result of the weekly audits will be reported to the Quality Assurance Committee (Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Social Service Director, Medical Records, Housekeeping and Laundry Supervisor, Therapy Manager, MDS Coordinator Activities Director and Pharmacy Consultant), monthly for 3 months for further review or corrective action if indicated. Date of completion November 01, 2013.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record reivew, observation, interview, and review of facility policy, the facility failed to coordinate care for a hospice resident	F 309		

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F 309	Continued From page 3 (#51) and failed to follow a physician's order for a nutritional supplement for one (#32) of thirty-five residents reviewed. The findings included: Resident #51 was admitted to the facility on April 30, 2012, with diagnoses including Bipolar Affective Disorder, Congestive Heart Failure, Diabetes Mellitus, Alzheimer's Disease, Chronic Obstructive Pulmonary Disease, and Parkinson's Disease. Observation on October 15, 2013, from 8:10 a.m. to 9:25 a.m., in the resident's room, and from the nursing station directly across the hallway from the resident's room, revealed the resident with Parkinsonian symptoms (involuntary rhythmic movements of the torso, head, and extremities, tongue thrusting, grunting, and involuntary tremors of the extremities associated with advanced Parkinson's Disease). Continued observation revealed the resident was agitated and calling out to the spouse and staff members for assistance repetitively. Interview with the resident's spouse on October 15, 2013, at 9:35 a.m., in the resident's room, revealed the resident was terminally ill due to Parkinson's disease and received hospice services in the facility. Further interview revealed agitation and severe anxiety were an ongoing problem for the resident. Continued interview revealed the behaviors observed occurred during each spousal visit, and usually lasted several hours after the visits ended. Further interview revealed the resident's anxiety had become more prominent "over the past several weeks". Continued interview revealed the spouse visited	F 309	**F 309** **PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** It is the policy of this facility to provide each resident with the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being, in accordance with the comprehensive assessment and plan of care. The hospice provider for resident #51 was contacted on October 15 ,2013 and notified of increased anxiety and restlessness. Resident #51 received antianxiety and pain medication without relief of symptoms. The hospice nurse was called to the facility to assess the resident. A new order was received for symptoms of anxiety. The resident continued to receive prn pain medication and hospice was called again regarding anxiety and restlessness. The Medical Director was also called and an additional order was received from the Medical Director. The resident received additional medication that relieved her symptoms. The hospice provider for resident #51 was contacted by the Director of Nursing, who requested that visit notes for all visits after August 23, 2013 and the hospice care plan be brought to the facility. Upon review by the Director of Nursing, the visit notes were provided for the medical record, but the hospice plan of care was not. Hospice services with resident #51's hospice provider have been terminated and hospice services are being	

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F 309	Continued From page 4 the resident in the facility at least twice weekly for several hours. Continued interview revealed the spouse was unaware of any non-pharmacologic interventions the hospice provider had ordered to reduce the resident's anxiety levels. Observation on October 15, 2013, from 2:45 to 3:45 p.m., in the resident's room, and from the nursing station directly across the hallway from the resident's room, revealed no reduction in the Parkinsonian symptoms or agitation for the resident. Medical record review revealed the facility did not have a copy of the hospice care plan on file in the chart. Continued medical record review revealed no hospice documentation present in the medical record after August 23, 2013. Review of the facility policy, Hospice Program (revised December 2011) revealed, "...when a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency, and resident/family will be developed and shall include directives for managing...other uncomfortable symptoms...care plan shall be revised and updated as necessary to reflect the resident's current status..." Interview with Licensed Practical Nurse (LPN) #4 on October 15, 2013, at 3:50 p.m., at the nursing station, confirmed the resident received hospice services in the facility. Continued interview confirmed the resident had received a hospice visit earlier, around 10:55 a.m., which included medication adjustments. When questioned as to what specific non-pharmacologic interventions hospice had ordered in addition to medications, to reduce the resident's anxiety and agitation, LPN	F 309	provided by an alternative provider selected by resident #51 family. All hospice residents could potential to be affect ted, the Director of Nursing and the Assistant Director of Nursing reviewed the medical records for all residents receiving hospice services to ensure compliance with the regulations. To ensure compliance with hospice services provided to residents in the facility, the Director of Nursing will review hospice medical records monthly for three months and review medical records for any new hospice admissions to ensure coordination of facility and hospice plan of care. The Director of Nursing will monitor compliance with the facility MDS coordinator. The Director of Nursing will report findings of the review process to the Quality Assurance Committee (Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Social Service Director, Medical Records, Housekeeping and Laundry Supervisor, Therapy Manager, MDS Coordinator Activities Director and Pharmacy Consultant), monthly for 3 months for further review or corrective action if indicated. Resident #32refused to drink her boost supplement and a sandwich had been substituted by the restorative aide. The Medical Director was informed of the substitution and a clarification order was written for the	

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F 309	Continued From page 5 #4 replied, "I am not sure". Interview with the Director of Nursing (DON) on October 15, 2013, at 4:05 p.m., in the nursing station, confirmed the facility failed to maintain copies of the hospice care plan and documentation of hospice care visits on the medical record, and failed to coordinate the facility's care plan with the hospice provider care plan. Resident #32 was admitted to the faciltiy on June 6, 2007, with diagnoses including Dementia, Psychosis, and Anxiety. Medical record review revealed the resident weighed 101 lbs. (pounds) on May 1, 2013, and on August 1, 2013, the resident weighed 96 lbs. Medical record review revealed a physician's order dated August 1, 2013, for Boost (dietary supplement with high calories and protein) three times daily for weight loss. Medical record review revealed no documentation the resident received the supplement. Interview with the Restorative Dining Aide, in the hallway, on October 16, 2013, at 12:30 p.m., confirmed the resident did not receive Boost because the resident did not like it and would not drink it. Interview with the physician, in the Director of Nursing's office, on October 16, 2013, at 12:35 p.m., confirmed the physician was unaware the resident had not been receiving the supplement. Continued interview confirmed if the physician had know the resident would not drink the	F 309	substitution and signed by the Medical Director on October 16, 2013 Any residents who received supplements could have been affected; nutritional supplements for all residents who receive them were reviewed by the Director of Nursing with the restorative aide. No other resident was affected. A new system for documenting nutritional supplements was initiated by the Director of Nursing and reviewed with the restorative aides. To ensure compliance, the Director of Nursing will review nutritional supplements weekly for four weeks, then monthly for three months. Findings of the reviews will be submitted to the Quality Assurance Committee(Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Social Service Director, Medical Records, Housekeeping and Laundry Supervisor, Therapy Manager, MDS Coordinator Activities Director and Pharmacy Consultant), monthly for four months for further review or corrective action if indicated. Date of completion November 10, 2013.	

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F 309	Continued From page 6 supplement, something else would have been ordered.	F 309	**F 371** **FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY** A complete audit of the Dietary Department was made by the Dietary Manager on October 16, 2013, to ensure that everything has a proper label and dated. In-service of the dietary staff, completed by the Dietary Manger and the Register Dietitian regarding the policy and procedure for proper labeling and dating on October 31, 2013. The Dietary Manager will conduct a daily audit on labeling and dating of open food for the next two weeks and continue the audit for three times a week for one week, followed by twice a week for one week. The audit will continue weekly for two months. The results of the audit will determine if any further education or monitoring is needed. The Dietary Manger is to monitor the results of the audit for the next three months. The results of the audit will be reported by the Dietary Manager to the Quality Assurance Committee (Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Social Service Director, Medical Records, Housekeeping and Laundry Supervisor, Therapy Manager, MDS Coordinator Activities Director and Pharmacy Consultant), monthly for three months for further review or corrective action if	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to ensure food was labeled and failed to ensure employee beverages were not stored in the cooler utilized for residents' food in the Dietary Department. The findings included: Observation on October 14, 2013, at 9:45 a.m., with the dietary manager, in the dietary department, revealed the following: 1. one tray of twelve prepared ham sandwiches on a hoagie bun stored in the cooler and not dated; 2. two trays of forty prepared ham sandwiches on sliced bread stored in the cooler and not dated; and 3. two plastic two liter bottles of cola one-quarter full opened and not dated stored in the cooler.	F 371		

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F 371	Continued From page 7 Review of facility policy, Food and Supply Storage Procedures, not dated, revealed "...cover, label, date..." Interview with the dietary manager on October 14, 2013, at 9:45 a.m., in the dietary department, confirmed the ham sandwiches were to be dated and the two liter bottles of cola were employee beverages and not to be stored in the residents' food cooler.	F 371	indicated. Date of completion November 01, 2013.	